

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005009

Facility Name: Sunny Acres Nursing Home

Address: Rural Route 3 Petersburg 62675
 Number City Zip Code

County: Menard

Telephone Number: 217-632-2334 **Fax #** 217-632-7092

IDPA ID Number: 37-605977001

Date of Initial License for Current Owners: 1966

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Michael J. Feriozzi C.P.A. **Telephone Number:** 217-522-8689

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12-01-04 to 11-30-05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Lester E. Robertson Jr.</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Michael J. Feriozzi, C.P.A.</u> <u>Certified Public Accountant</u>	
	(Firm Name & Address) <u>Michael J. Feriozzi, C.P.A.</u> <u>1316 South Glenwood Avenue Springfield, Illinois 62704</u>	
	(Telephone) <u>217-522-8689</u> Fax # <u>217-632-7092</u>	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number Sunny Acres Nursing Home# 0005009 Report Period Beginning: 12-01-04 Ending: 11-30-05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 106

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>106</u>	Skilled (SNF)	<u>106</u>	<u>38,690</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>106</u>	TOTALS	<u>106</u>	<u>38,690</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,994</u>	<u>11,058</u>	<u>3,635</u>	<u>32,687</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,994</u>	<u>11,058</u>	<u>3,635</u>	<u>32,687</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.48%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

noneF. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1966

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 106 and days of care provided 3,635Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO N/ATax Year: N/A Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-04 Ending: 11-30-05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	196,007	20,785	5,931	222,723		222,723		222,723			1
2	Food Purchase		212,209		212,209	(32,000)	180,209	(19,290)	160,919			2
3	Housekeeping	125,878	24,865		150,743		150,743		150,743			3
4	Laundry	53,702	10,577		64,279		64,279		64,279			4
5	Heat and Other Utilities			141,627	141,627		141,627		141,627			5
6	Maintenance	56,631	62,245	5,979	124,855		124,855		124,855			6
7	Other (specify):*											7
8	TOTAL General Services	432,218	330,681	153,537	916,436	(32,000)	884,436	(19,290)	865,146			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,322,230	199,179	218,716	1,740,125	(93,213)	1,646,912	(23,994)	1,622,918			10
10a	Therapy	30,822	13,096	285,607	329,525	(298,703)	30,822		30,822			10a
11	Activities	61,955	6,683		68,638		68,638		68,638			11
12	Social Services	78,386	2,000	3,167	83,553		83,553		83,553			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,493,393	220,958	519,490	2,233,841	(391,916)	1,841,925	(23,994)	1,817,931			16
	C. General Administration											
17	Administrative	33,015	18,504	26,549	78,068		78,068		78,068			17
18	Directors Fees											18
19	Professional Services			149,572	149,572		149,572		149,572			19
20	Dues, Fees, Subscriptions & Promotions			25,131	25,131		25,131	(11,084)	14,047			20
21	Clerical & General Office Expenses	50,866	11,191	43,833	105,890		105,890	(43,833)	62,057			21
22	Employee Benefits & Payroll Taxes			354,905	354,905	32,000	386,905		386,905			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,009	13,009		13,009		13,009			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,999	61,999		61,999		61,999			26
27	Other (specify):*											27
28	TOTAL General Administration	83,881	29,695	674,998	788,574	32,000	820,574	(54,917)	765,657			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,009,492	581,334	1,348,025	3,938,851	(391,916)	3,546,935	(98,201)	3,448,734			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sunny Acres Nursing Home #0005009 Report Period Beginning: 12-01-04 Ending: 11-30-05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			174,029	174,029		174,029		174,029			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,731	31,731		31,731	(31,731)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			205,760	205,760		205,760	(31,731)	174,029			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					391,916	391,916		391,916			39
40	Barber and Beauty Shops	10,893	454		11,347		11,347	(11,347)				40
41	Coffee and Gift Shops		3,609		3,609		3,609	(3,609)				41
42	Provider Participation Fee			58,034	58,034		58,034		58,034			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	10,893	4,063	58,034	72,990	391,916	464,906	(14,956)	449,950			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,020,385	585,397	1,611,819	4,217,601		4,217,601	(144,888)	4,072,713			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-04

Ending: 11-30-05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(19,290)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(31,731)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,803)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,030)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,084)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,938)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (105,938)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology	x		13,034	line 10	42
43	Prescription Drugs	x		80,179	line 10	43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule	x		32,000	line 2	45
46	Other-Attach Schedule	x		298,703	line 10a	46
47	TOTAL (C): (sum of lines 38-46)			\$ 423,916		47

Sunny Acres Nursing Home

ID# 0005009

Report Period Beginning: 12-01-04

Ending: 11-30-05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	medical supplies sold to residents	\$ (23,994)	10	1
2	hair care revenues	(11,347)	40	2
3	coffee and gift shop	(3,609)	41	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(38,950)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04

Ending:

11-30-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(19,290)	0	0	0	0	0	0	0	0	0	0	(19,290)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(19,290)	0	0	0	0	0	0	0	0	0	0	(19,290)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(23,994)	0	0	0	0	0	0	0	0	0	0	(23,994)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(23,994)	0	0	0	0	0	0	0	0	0	0	(23,994)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,084)	0	0	0	0	0	0	0	0	0	0	(11,084)	20
21	Clerical & General Office Expenses	(43,833)	0	0	0	0	0	0	0	0	0	0	(43,833)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(54,917)	0	0	0	0	0	0	0	0	0	0	(54,917)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(98,201)	0	0	0	0	0	0	0	0	0	0	(98,201)	29

STATE OF ILLINOIS

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04 Ending:

Summary B

11-30-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,731)	0	0	0	0	0	0	0	0	0	0	(31,731)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,731)	0	(31,731)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(11,347)	0	0	0	0	0	0	0	0	0	0	(11,347)	40
41	Coffee and Gift Shops	(3,609)	0	0	0	0	0	0	0	0	0	0	(3,609)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(14,956)	0	(14,956)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(144,888)	0	(144,888)	45									

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04

Ending:

11-30-05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Menard County, Illinois	100	none		Countryside Estates of the County	Petersburg, Illinois	independent living facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-04 Ending: 11-30-05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04

Ending: 11-30-05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Menard County General	x		interim working capital	\$6,120.00	11-30-05	73,434	73,434	11-30-06	0.0350	none	6								
7	Fund											7								
8												8								
9	TOTAL Facility Related				\$6,120.00		\$ 73,434	\$ 73,434				9								
B. Non-Facility Related*																				
10	nursing home revenue		x	to partially finance	\$16,610.00	04-28-98	1,550,000	550,000	04-28-08	0.0483	31,731	10								
11	bonds			the construction of an								11								
12				independent living facility								12								
13												13								
14	TOTAL Non-Facility Related				\$16,610.00		\$ 1,550,000	\$ 550,000			\$ 31,731	14								
15	TOTALS (line 9+line14)						\$ 1,623,434	\$ 623,434			\$ 31,731	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2000	_____	8		
2001	_____	9		
2002	_____	10		
2003	_____	11		
2004	_____	12		
			FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunny Acres Nursing Home COUNTY Menard

FACILITY IDPH LICENSE NUMBER 0005009

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Sunny Acres Nursing Home

0005009 Report Period Beginning:

12-01-04 Ending:

11-30-05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,190 B. General Construction Type: Exterior brick Frame protected noncombust Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Estates of the County is an independent living facility located adjacent to Sunny Acres Nursing Home. The financial operations of Countryside Estates of the County are accounted for in a separate and distinct Menard County fund, as are the financial operations of Sunny Acres Nursing Home. Menard County issued revenue bonds in April, 1998 through the Sunny Acres Nursing Home Fund to partially finance the construction of the facility for the operation of Countryside Estates of the County. That portion of the facility construction project not financed with the revenue bond proceeds was financed with funds provided by the Sunny Acres Nursing Fund in the amount of \$1,071,628.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>land that the nursing home's and independent</u>		<u>1966</u>	\$	1
2	<u>living facility's buildings are situated on</u>			<u>25,000</u>	2
3	TOTALS			\$ 25,000	3

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04

Ending:

11-30-05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1966	1966	\$ 526,787	\$ 13,170	40	\$ 13,170		\$ 493,866	4
5	38		1977	1977	568,714	14,218	40	14,218		398,103	5
6			1984	1984	61,842	2,061	30	2,061		44,315	6
7	10		1993	1993	654,160	16,354	40	16,354		198,974	7
8			1995	1995	68,999	3,450	20	3,450		34,501	8
	Improvement Type**										
9		generator		1980	28,901		10			28,901	9
10		fire alarm system		1981	9,805		10			9,805	10
11		none		1982							11
12		gazebo and floor coverings		1983	12,750	333	20-25	333		11,914	12
13		flooring, phone, and paging systems, air conditioner		1984	30,885	502	10-25	502		29,122	13
14		sun room, remodelling, wallpaper		1985	7,061	143	5-30	143		5,854	14
15		kitchen remodelling, wallpaper, parking lot, nightlight, etc		1986	36,333	650	5-25	650		35,410	15
16		boiler repair, sprinkler system, office remodelling, air conditioner		1987	17,193	154	5-25	154		16,379	16
17		roof, chimney, carpeting, sprinkler system,		1988	147,826	80	5-25	80		146,934	17
18		compressor, canopy, carport		1989	6,472	138	15-30	138		4,626	18
19		asbestos removal, flooring, water heater, landscaping, canopy		1990	28,642	991	5-30	991		19,063	19
20		main air conditioning unit		1991	5,194	346	15	346		5,048	20
21		none		1992							21
22		new lagoon, tiling, hot water heater, aviary		1993	223,851	38,147	5-30	38,147		219,605	22
23		fill old lagoon, flooring, wallpaper, and sign		1994	49,671	513	5-25	513		44,226	23
24		major boiler repair, air conditioners, ceiling tile replacement		1995	10,685	450	5-10	450		10,523	24
25		special needs unit, resident walking gardens, vinyl soffets		1996	139,517	6,048	5-30	6,048		64,465	25
26		donor recognitions wall, remodelling, draperies, shades		1997	20,798	300	5-10	300		20,413	26
27		major boiler repair, air conditioners, ceiling tile replacement		1998	21,699	2,007	10-15	2,007		14,757	27
28		two commercial water heaters, entrybath, rooftop air conditioner		1999	41,844	4,750	7-10	4,750		30,854	28
29		plumbing improvements, structural improvements		2000	18,896		5			18,896	29
30		plumbing, electrical, boiler rehabilitation		2001	22,162	4,432	5	4,432		19,945	30
31		structural improvements, sewer line and walls		2002	77,846	5,618	10-15	5,618		17,790	31
32		seal parking lot, fence improvements		2003	16,153	2,164	5-10	2,164		4,943	32
33		flooring, alarm systems, office remodelling etc		2004	67,361	5,532	10-20	5,532		8,370	33
34		kitchen tile and ceiling, carpeting, drapes, circuit improvements		2005	17,158	858	10	858		858	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04

Ending:

11-30-05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,939,205	\$ 123,409		\$ 123,409	\$	\$ 1,958,460	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-04 Ending: 11-30-05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 346,709	\$ 16,409	\$ 16,409	\$	5-20	\$ 235,672	71
72	Current Year Purchases	47,733	4,700	4,700		5-7	4,605	72
73	Fully Depreciated Assets	446,441	29,511	29,511		5-20	446,441	73
74								74
75	TOTALS	\$ 840,883	\$ 50,620	\$ 50,620	\$		\$ 686,718	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$	3	\$	76
77	facility operations	1989 van	1989	20,735				3	20,735	77
78	facility operations	1989 van overhaul	1993	1,585				3	1,585	78
79										79
80	TOTALS			\$ 22,320	\$	\$	\$		\$ 22,320	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,827,408	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 174,029	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 174,029	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,667,498	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>120</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	<u>6</u>
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a column 2&3	hrs	\$		\$ 115,865	\$ 5,313		\$ 121,178	1
2	Licensed Speech and Language Development Therapist	10a column 2&3	hrs			16,610	762		17,372	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a column 2&3	hrs			153,132	7,021		160,153	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10 column 2	# of prescripts				80,179		80,179	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	10 column 2					13,034		13,034	13
14	TOTAL			\$		\$ 285,607	\$ 106,309		\$ 391,916	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Sunny Acres Nursing Home # 0005009 Report Period Beginning: 12-01-04 Ending: 11-30-05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11-30-05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$ 93,457	1
2	Cash-Patient Deposits	9,234	9,234	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>83,807</u>)	521,672	647,873	3
4	Supply Inventory (priced at <u>fifo cost</u>)	18,000	21,517	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,586	4,586	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 553,492	\$ 776,667	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,998,389		12
13	Land			13
14	Buildings, at Historical Cost	2,939,208	5,271,699	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	863,200	953,963	16
17	Accumulated Depreciation (book methods)	(2,667,498)	(3,298,253)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		9,155	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,946)	20
21	Restricted Funds	1,103,606	1,103,606	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,236,905	\$ 4,033,224	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,790,397	\$ 4,809,891	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 296,571	\$ 309,365	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,234	15,934	28
29	Short-Term Notes Payable	248,434	248,434	29
30	Accrued Salaries Payable	142,499	142,499	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,156	29,156	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,293	2,293	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 728,187	\$ 747,681	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	375,000	375,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 375,000	\$ 375,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,103,187	\$ 1,122,681	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,687,210	\$ 3,687,210	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,790,397	\$ 4,809,891	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,370,510	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,370,510	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	352,700	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 352,700	17
B. Transfers (Itemize):			
18	transfer to the general fund, a partial return of	(36,000)	18
19	contributed capital		19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (36,000)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,687,210	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sunny Acres Nursing Home# 0005009Report Period Beginning: 12-01-04Ending: 11-30-05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,480,244	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,480,244	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,074	12
13	Barber and Beauty Care	12,979	13
14	Non-Patient Meals	19,290	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,994	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 61,337	23
D. Non-Operating Revenue			
24	Contributions	17,367	24
25	Interest and Other Investment Income***	11,353	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,720	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,570,301	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	916,436	31
32	Health Care	2,233,841	32
33	General Administration	788,574	33
B. Capital Expense			
34	Ownership	205,760	34
C. Ancillary Expense			
35	Special Cost Centers	14,956	35
36	Provider Participation Fee	58,034	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,217,601	40
41	Income before Income Taxes (line 30 minus line 40)**	352,700	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 352,700	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning:

12-01-04

Ending:

11-30-05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,950	2,165	\$ 49,861	\$ 23.03	1
2	Assistant Director of Nursing	1,990	2,158	40,578	18.80	2
3	Registered Nurses	6,854	7,384	141,794	19.20	3
4	Licensed Practical Nurses	19,946	21,479	351,262	16.35	4
5	CNAs & Orderlies	63,350	68,011	716,076	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,024	2,324	30,822	13.26	8
9	Activity Director	1,805	2,086	26,923	12.91	9
10	Activity Assistants	4,180	4,490	35,032	7.80	10
11	Social Service Workers	5,993	6,720	78,386	11.66	11
12	Dietician					12
13	Food Service Supervisor	914	989	12,213	12.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,175	8,997	82,907	9.21	15
16	Dishwashers	13,415	13,976	100,887	7.22	16
17	Maintenance Workers	5,073	5,390	56,631	10.51	17
18	Housekeepers	11,795	13,226	125,878	9.52	18
19	Laundry	7,237	7,588	53,702	7.08	19
20	Administrator	908	995	33,015	33.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,784	4,227	50,866	12.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,526	1,670	22,659	13.57	32
33	Other(specify)	957	1,022	10,893	10.66	33
34	TOTAL (lines 1 - 33)	161,876	174,897	\$ 2,020,385 *	\$ 11.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	169	\$ 5,931	line 1 (3)	35
36	Medical Director	120	12,000	line 9 (3)	36
37	Medical Records Consultant	50	1,500	line 10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,200	line 10 (3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	50	3,167	line 12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	413	\$ 23,798		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	61	\$ 2,004	line 10 c	50
51	Licensed Practical Nurses	2,931	96,426	line 10 c	51
52	Certified Nurse Assistants/Aides	6,548	117,586	line 10 c	52
53	TOTAL (lines 50 - 52)	9,540	\$ 216,016		53

Facility Name & ID Number Sunny Acres Nursing Home

0005009

Report Period Beginning: 12-01-04

Ending: 11-30-05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lester E. Robertson Jr.	administrator	0	\$ 33,015	Workers' Compensation Insurance	\$ 82,339	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	13,544	Advertising: Employee Recruitment	22,032	
				FICA Taxes	147,901	Health Care Worker Background Check	2,104	
				Employee Health Insurance	82,572	(Indicate # of checks performed <u>132</u>)		
				Employee Meals	32,000			
				Illinois Municipal Retirement Fund (IMRF)*	28,549	Advertising amount above is all advertising. The cost of adds for employee recruitment was \$5190.		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 33,015			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	(11,084)	
management information systems support			\$ 18,243					
employee party and awards			8,306					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 26,549	TOTAL (agree to Schedule V, line 22, col.8)	\$ 386,905	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,047	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Michael J. Feriozzi, CPA	audit and accounting		\$ 19,800				Out-of-State Travel	\$ 0
Revere Healthcare Ltd.	medicare consulting		6,023					
Revere Healthcare Ltd.	interim administrator		63,335				In-State Travel	4,184
Revere Healthcare Ltd.	financial consulting, cfo		44,844					
Administrative Services	cafeteria plan administration		2,970				Seminar Expense	8,825
Tobin, Merritt & Associates	administrator recruitment		12,600					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 149,572	TOTAL		\$ none	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	\$ 13,009

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. LSN and IHCA \$7,728
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? 106
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,621 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. na
- (9) Are you presently operating under a sublease agreement? _____ YES no NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES na NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
na
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 58,034
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? na
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 32,000 Has any meal income been offset against related costs? yes Indicate the amount. \$ 19,290
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ na
- c. What percent of all travel expense relates to transportation of nurses and patients? 80%
- d. Have vehicle usage logs been maintained? na
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? na
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? na
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ na
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Michael J. Feriozzi C.P.A. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. will be provided in April,2006
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? na
Attach invoices and a summary of services for all architect and appraisal fees.

Section VI, Adjustment Detail, Part C, Line 45

The amount, \$32,000, is the computed cost of employee provided meals during the year ended November 30, 2005.

Section VI, Adjustment Detail, Part C, Line 45

The amount, \$298,703, consists of the following-----

Cost of licensed occupational therapist services	121,178
Cost of licensed speech therapist services	17,372
Cost of licensed physical therapist services	<u>160,153</u>
	<u>298,703</u>

Section XIV Special Services Line 13 Other

Cost of radiology services	4,391
Cost of laboratory services	<u>8,643</u>
	<u>13,034</u>

Schedule XV, balance sheet, explanation of consolidation column

The consolidation presents Sunny Acres Nursing Home and its investment in Countryside Estates of the County and the County's equity in the Sunny Acres Intergovernmental Transfer Fund. The financial reporting entity is discussed in the notes to the audited financial statements for Sunny Acres Nursing Home for the year ended November 30, 2005.

Schedule XV, balance sheet, line 29 short-term notes payable

Working capital loan from the Menard County General Fund	73,434
Current portion of long term debt	<u>175,000</u>
	<u>248,434</u>